ADMINISTRATIVE SERVICES AGREEMENT
By and between

MONTGOMERY COUNTY GOVERNMENT

and
Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

JANUARY 1, 2004 AMENDMENT
Point-of-Service Plan

This amendment is effective January 1, 2004. Notwithstanding any provision, exclusion or reference to the contrary, the Contract is amended as follows:

All references to the Maryland Insurance Administration in the Certificate of Coverage are herby deleted.

APPEALS AND GRIEVANCES

The Certificate of Coverage, Section 6, Member Grievance Procedures and any references to the Grievance and Appeals Procedures is deleted and replaced by the following:

CareFirst's appeal procedure is designed to enable you to have your concerns regarding a denial of benefits or authorization for services heard and resolved. By following the steps outlined below, you can ensure that your appeal is quickly and responsively addressed. *Refer to your Evidence of Coverage for more specific information regarding your appeal process.*

An expedited appeal process has been established in the event that a delay in a decision would be detrimental to your health or the health of a covered family member. In an expedited appeal, a decision by CareFirst shall be made within 24 hours, and review will be done by a peer of the patient's treating healthcare provider, if additional information would not change the Plan's decision. Expedited Appeals involve care that has not yet occurred or is currently occurring. (Pre Service or concurrent care).

Step 1: Discussion of the Problem
Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst member services representative. In many instances, the matter can be quickly resolved.

Step 2: Appeal/ Grievance Process
If your concern is not resolved through a discussion with a CareFirst representative, you or someone on your behalf may make a formal request for appeal. CareFirst must receive the request within 180 days or six months of the date of the notification of denial of benefits or services. If the request for appeal is related to a medical issue, a peer of the patient's treating health care provider, not part of the original denial decision, will review the request. This request should be in writing and addressed to the Member Services Department, and shall state the reason of the request. A Member Services representative will be available to assist you in submitting your appeal in the event you are unable to put the request in writing.

All appeal decisions will be rendered in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how that decision was made. Included in this written appeal decision will be an explanation of the appropriate next steps a member may take if they are not satisfied with the appeal decision.

PLAN PROVIDER REFERRALS

Certain terms that have a specific meaning as used herein. These terms are capitalized and defined in Section 1.1 below and in Section 1 of the Certificate of Coverage to which this amendment is attached.

Notwithstanding any provision to the contrary, any reference to the Seamless POS Amendment has been deleted. The Certificate of Coverage is amended as follows:

1.1 **Definitions.** Any reference to "Primary Care Physician" is hereby deleted and replaced with "Primary Care Provider". Any definition of "Primary Care Physician" is hereby deleted and replaced with the following:

Primary Care Provider means a Plan Physician or Plan Provider selected by a Member to provide and manage the Member's health care.

1.2 **Benefits for Services Provided by a Plan Provider Specialist.** Members are not required to obtain referrals in order to receive benefits for covered services provided by Plan Provider specialists. This amendment also eliminates the need to obtain standing referrals to Plan Provider specialists for conditions or diseases that are life threatening, degenerative, chronic, or disabling, and which require specialized medical care.

1.3 **In-Network Utilization Management.** Members may self-refer to Plan Provider specialists, however, some services require pre-authorization from CareFirst BlueChoice's Utilization Management program, as stated in the evidence of coverage and in this amendment. All Utilization Management requirements contained in the evidence of coverage apply to the provisions of this amendment, in addition to the requirements below.

A. In addition to the services listed in the evidence of coverage that must be authorized or approved by CareFirst BlueChoice, the services listed below require prior authorization from CareFirst BlueChoice to be eligible for benefits:

1. Habilitative Services;

2. Covered infertility services; and

3. Chiropractic Services.

B. Outpatient Mental Health and Substance Abuse Services must be pre-authorized by CareFirst BlueChoice's Mental Health Management Program. The Member or the Member's treating provider must contact the Mental Health Management Program for authorization.

C. Inpatient Hospital Services, Skilled Nursing Services, and Hospice Services. Members may receive benefits for covered Inpatient Hospital Services, Skilled Nursing services, and Hospice Services when admitted under the care of the Member's Primary Care Provider or by another Plan Provider, whether or not the Member was referred to that Provider by the Primary Care Provider, providing that the services have been pre-authorized under CareFirst BlueChoice's Utilization Management program.

D. Outpatient Rehabilitation Services. Pre-authorization is not required for covered outpatient physical therapy, speech therapy, or occupational therapy services.

NOTE: Utilization Management may include additional aspects such as second surgical opinion and/or pre-admission testing requirements, concurrent review, discharge planning and case management. Failure or refusal of the Member to comply with notice requirements and other CareFirst BlueChoice authorization and approval procedures will result in exclusion of services from coverage, even if the services are Medically Necessary.

ADDRESS CHANGE

All references to the corporate address of Group Hospitalization and Medical Services, Inc., in the Certificate of Coverage, listed as:

550 12th Street, SW
Washington, DC 20065

are hereby deleted and replaced with:

840 First Street, NE
Washington, DC 20065

This amendment is subject to all the terms and conditions of the Group Contract and Certificate of Coverage to which this Amendment applies. This amendment does not change the terms and conditions of the evidence of coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

William L. Jews
President and Chief Executive Officer